ADULT CA

SAFEGUARDING ADULTS REVIEW

This report has been commissioned and prepared on behalf of Manchester Safeguarding Adults Board and is available for publication on the 2nd March 2018

INDEPENDENT LEAD REVIEWER: Hayley Frame

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1. Introduction

1.1 Criteria

A Local Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR).

An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.

Condition 1 is met if:

(a) the adult has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if:

(a) the adult is still alive, and
(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:

(a) identifying the lessons to be learnt from the adult's case, and
(b) applying those lessons to future cases.

2. Decision to hold a Safeguarding Adults Review (SAR)

2.1 Following a referral by Greater Manchester Police (GMP) to the Manchester Safeguarding Adults Board (MSAB) on 24th March 2016, a decision was made that the criteria for a SAR were met under condition 1 as set out above.

2.2 The circumstances of the referral were that Adult CA had been found deceased on 15th March 2016 having sustained head injuries. It appeared that CA had jumped from a bridge. A note of intent was found in CA's pocket.

3. Methodology

3.1 The methodology for this SAR has been developed to ensure the learning is gained in an effective and timely way, in line with the Care Act 2014 requirements. Key aspects of the process included:

- Consideration of multi-agency information submitted, including chronologies and appraisal reports.
- The formation of a SAR Panel to consider agency information and agree Overview report
- Practitioner event to reflect upon the learning.
- Individual conversations with practitioners who had contact with Adult CA.

3.2 Hayley Frame, Independent Reviewer, was appointed to undertake the SAR.

4. Time period over which events should be reviewed

4.1 It was agreed by the MSAB SAR subgroup that the review would focus upon events occurring between 1st July 2013 and the point of Adult CA's death.

5. Organisations involved in the SAR

5.1 Organisations involved in the SAR were as follows:

- Greater Manchester Police (GMP)
- Central Manchester NHS Foundation Trust (CMFT)
- Manchester Mental Health & Social Care Trust (MMHSCT)
- NHS Manchester CCG
- GM & Cheshire Community Rehabilitation Company (GMC CRS)
- GMW / Manchester Offenders Division, Engagement & Liaison (MODEL)
- MIDAS
- Manchester City Council (Domestic Violence Reduction Co-ordinator)
- North West Ambulance Service (NWAS).

6. Involvement of Family Members and Significant Others

6.1 The mother of Adult CA was contacted to share the findings of this report.

7. Parallel Investigations

7.1 An inquest in respect of Adult CA has been opened and adjourned.

8. Case Summary

8.1 Adult CA was a 22 year old young person known to mental health services since the age of 16. Adult CA had a history of anxiety, self-harm and alcohol and substance misuse. CA had been diagnosed as an adult with an emotionally unstable personality disorder; was under the care of adult psychiatry outpatients; and had an assessment appointment due with the psychology complex cases services. It was known that CA had ended an abusive relationship. At the time of CA's death, they were known to mental health services; the police; the Community Rehabilitation Company (following a conviction for an assault against their mother); Acute hospital services (Emergency Department); Community Alcohol Services and the IDVA Services (as a perpetrator of violence towards their mother).

8.2 As the scoping period covered several years, the agency information was extensive and the merged chronology exceeded 200 pages. It was therefore agreed by the SAR Panel to focus upon key practice events within the chronology and the following is a concise summary of the relevant case information, with greater detail in the months preceding CA's death.

8.3 On 29th June 2014, the police were called to a domestic incident between CA, CA's then partner and CA's mother. The argument had caused CA to have a panic attack and an ambulance was called. CA was later reported as missing from the hospital they had been taken to, having last been observed saying that they wanted to kill themself and banging their head against a wall. CA was later visited by the police at home and agreed to attend the GPs surgery the next day.

8.4 On 27th June 2015, CA contacted the police to state that their partner was going to throw themself from a building. Upon attendance the police found CA and partner to be safe but intoxicated. It was believed that CA was delusional after alcohol and legal high consumption.

8.5 CA was seen by their consultant psychiatrist on 1st June 2015 and diagnosed with borderline personality traits. CA disclosed a recent split from their partner of several years and had had a recent medical procedure. CA was unwilling to try medication.

8.6 CA took an overdose of tablets on 5th July 2015.

8.7 On 29th July 2015, the police and ambulance service were contacted by CA's mother as CA was distressed and banging their head against the wall. CA refused to attend hospital. A referral was made to adult social care which was directed to the mental health trust. A further referral was made on 7th August 2015 when CA was again threatening to harm themself.

8.8 CA was seen in outpatients' psychiatry on 18th August 2015. CA denied active thoughts of suicide. CA disclosed drinking alcohol daily and taking tablets out of impulse when drunk. It was agreed to commence medication and a referral to be made to psychology services.

8.9 On 26th August 2015, the police were alerted to CA having climbed onto a first floor roof and had only been prevented from jumping by their friends. CA was subsequently taken to hospital and detained under s136 Mental Health Act[1]. CA was assessed as high risk and a referral made to adult social care.

8.10 The ambulance service made a safeguarding referral on 3rd September 2015 which was passed to the mental health trust. Concerns were in relation to self-harm and domestic abuse - CA was seen to have bruising to their upper arms, stating their mother had done it when CA had fallen over drunk. CA was not willing to engage with the subsequent safeguarding process.

8.11 On 18th September 2015, CA was arrested for assault against their mother including punching, pulling hair and forcing their mother to kiss their feet. As CA's mother did not wish to support prosecution the case was discontinued. A MARAC referral was made with CA's mother as the victim.

8.12 On 9th November 2015, the police were called and CA was found to be having a panic attack and banging their head on the wall. CA's mother disclosed having been assaulted by CA including being dragged to the floor and bitten several times. CA had to be restrained in leg restraints and cuffs and was taken to hospital. Whilst at hospital CA's head wound was cleaned and it was noted that CA was due to see their psychiatrist the following week. A referral was made to the mental health team. CA was later charged with assault and remanded, soon after being bailed to reside at their father's address.

8.13 A MARAC was held on 1st December 2015, CA's mother was being supported by an IDVA and a restraining order was to be supported.

8.14 On 8th December 2015, CA was sentenced following the assault and required to engage for the purposes of rehabilitation with the Community Rehabilitation Company (CRC). A 12 month community order was made alongside a restraining order preventing contact with CA's mother. CA was referred to specialist services, Manchester Offenders Diversion, Engagement and Liaison (MODEL) Team and the Community Alcohol Team (CAT) with whom CA demonstrated positive engagement.

8.15 On 17th December 2015, CA was found intoxicated on the street and police and ambulance services attended. A referral was made to adult services and passed to the mental health trust.

[1] https://www.legislation.gov.uk/ukpga/1983/20/section/136

8.16 CA was seen in psychiatry outpatients on 2nd February 2016. It was recorded that CA was living with their father, had reduced their alcohol intake and had no active thoughts to self-harm. CA was referred back to psychology services having missed their initial appointment.

8.17 During February 2016, CA was seen by their MODEL worker, CAT and [specialist] worker. Contacts were positive and CA reported no significant alcohol use and no self-harm. On 26th February 2016, CA was seen by their MODEL worker and reported feeling positive. CA spoke of being aware that they would find their birthday difficult because they were not able to have contact with their mother and was aware of the impact of alcohol upon their wellbeing.

8.18 On 2nd March 2016, CA was seen by the Community Alcohol Team (CAT) and discharged from the service as CA was making progress, risks were reduced and CA did not want to be transferred to the new service that had won the tender as of 1st April 2016. However later that evening, CA's father contacted the police to report that CA was attacking him. CA was intoxicated. When the police attended, CA assaulted a police officer and was later charged for the offence. No safeguarding referral was made on this occasion.

8.19 CA was seen by their GP for a routine review of mediation on 7th March 2016.

8.20 On 11th March 2016, police and ambulance services were called to CA's father's address where CA had cut their arm and taken an overdose of an unknown substance. CA had a very deep cut that that penetrated all layers of skin and fat. It was recorded by the police officer that CA stated that they had nothing to live for and was not looking forward to their birthday in 3 days' time, and if they were out of hospital they would kill themself. No safeguarding referral was made as CA was taken to hospital by the ambulance crew. Ambulance logs note that CA had slurred speech and was reluctant to attend hospital. CA stated that they were feeling depressed and was upset about a forthcoming birthday. The ambulance crew passed on the concerns to the triage nurse in A&E with regard to CA's birthday being a potential trigger for further self-harm.

8.21 CA arrived at the hospital at 5.16am accompanied by their stepsibling. CA stated that they could not remember what they had used to cut their arm, was not feeling suicidal and just wanted to go to sleep. CA reported regularly drinking alcohol and smoking cannabis. CA was reviewed by the duty psychiatrist, in the company of their stepsibling, at 11.20am. CA stated that they were worried about their birthday the following week as the last few birthdays had been disappointing; CA was concerned that their father would make them homeless as they had been drinking and was worried about being sent to prison for the assault. CA denied feeling suicidal. CA was reluctant to answer questions, as they felt it would be more useful to talk to a psychologist who knew them rather than a duty psychiatrist and CA also wanted to go home to bed. Assurances were given by CA and their stepsibling that CA would remain safe at home and it was noted that CA had an appointment with psychology

services later that month and had a probation counsellor who they found helpful. CA was therefore discharged. The risk assessment before discharge was that CA was lucid, not intending to kill themself and had a follow up plan in place. It was determined that there was a high risk of CA self-harming in the future, particularly at the time of their birthday and the court case. Notification of the attendance was sent to the GP but not received until after CA's death.

8.22 On 15th March 2016, after having been out celebrating their birthday the previous evening, CA died.

8.23 On Wednesday 16th March 2016, CA's CRC case manager turned on their work mobile phone to find text messages, sent whilst the case manager was not at work, from CA describing very low mood and suicidal ideation.

9. Practitioner perspectives

9.1 The MODEL worker described CA as bright and articulate. CA could be optimistic and demonstrated signs of engagement. It was felt that CA engaged better with agencies in situations with structure and boundaries although their presentation could be inconsistent.

9.2 The impact of domestic abuse upon CA was deemed to be a key feature - CA observed domestic abuse as a child, CA's own relationship was abusive, with CA as the victim; yet CA was perceived as the perpetrator by domestic abuse services working with the mother.

9.3 Alcohol and drug misuse were a key feature of CA's life and CA would present very differently when intoxicated and in crisis. CA's acts of deliberate self-harm were not perceived as high risk until very late on, and it was felt that CA's presentation when sober and lucid, demonstrated insight into CA's difficulties and a willingness to accept help.

9.4 The CRC worker described how CA engaged very well and was open about their alcohol use, offending behaviour and relationship difficulties. CA was insightful and presented as stable. CA had spoken about not looking forward to their birthday as they wouldn't be able to see their mother, but there was nothing in CA's presentation that caused alarm and CA was not demonstrating suicidal ideation. CA had spoken about how they would manage family occasions without alcohol, and was aware that alcohol was a trigger. The CRC worker had not been aware of CA's presentation at A&E on 11th March and was very shocked and deeply affected by CA's death, as CA had presented positively within their work with them.

10. Analysis and emerging themes

Safeguarding Referrals

10.1 It is evident that the police made safeguarding referrals following their contacts with CA. These referrals went first to the internal vulnerable adults' team for screening. This would mean that there was a delay in the referral being received by adult social care and then transferring to the mental health trust for them to respond to given that they were the lead agency in the case and working with CA.

10.2 On 11th March 2016, the attending police officer made a very detailed report to the internal vulnerable adults' team. The officer classified CA as high risk. A safeguarding referral was not made to adult social care however, the rationale being that CA had been handed over to a medical agency and it would be for them to make any necessary referral, which was reported to be Force policy. The significance of this is that the medical agency may be unaware of the expectation the police have of them to make referrals. In addition, the risk is that the information (as in this case) may become diluted and the safeguarding risk not recognised or responded to effectively. It is the view of the SAR Panel that referral should be owned and acted upon at source of information.

10.3 The ambulance crew also expressed concern on 11th March 2016 which was passed on to the hospital triage nurse. However no safeguarding referral was made by the ambulance staff or hospital staff.

10.4 The Core Trainee doctor who assessed CA in hospital on 11th March 2016 appeared to be reassured by the stepsibling's undertaking that the family would keep CA safe and that CA had support services, including mental health services, in the community. No contact was made with these services, and safeguarding advice was not sought. CA was told to return to A&E if they felt suicidal. A referral to the mental health home treatment team could have been considered but did not occur. The doctor would have been unaware of MODEL involvement unless reported by CA. It is of note that the Psychiatry Liaison Team were short staffed on that shift and CA had been in the department for more than six hours and wanted to go home to sleep having been awake for over 24 hours.

10.5 It is clear that CA presented very differently when intoxicated. By the time CA was seen by the duty psychiatrist CA would have started to become sober and was described as lucid. Consideration should be given to how best to manage people, and assess them, at point of crisis. There is learning that could be taken from other police forces and mental health trusts that deploy a triage car, where an approved mental health practitioner accompanies a police officer to calls involving mental health concerns and deliberate self-harm. This allows for assessment at the point of crisis.

10.6 The impact of the lack of agency communication following CA's attendance at A&E on 11th March 2016 was that daytime services, in particular the CRC worker and MODEL worker, were unaware of the attendance.

10.7 Whether a safeguarding referral should have been made, and who by, has been explored within this SAR. There were three agencies that could have made a referral (hospital, ambulance and police) yet none was made. The sheer amount of incidents of people in crisis, who have self-harmed, and are intoxicated, that present themselves on a daily to these three agencies mean that judgement must be used when making a safeguarding referral. There is an obvious risk in not making safeguarding referrals yet it must be recognised that to refer all such cases could also be a risk given the numbers that this would result in that would require a response.

10.8 Referrals for pre-emptive action, when a crisis can be foreseen, will inevitably increase referral rates. A multi-agency referral pathway will help support agencies in making appropriate referrals.

10.9 In addition, consideration has been given to the timeliness of any response. CA was seen on a Friday and so it is likely that any safeguarding referral would not be processed until the following Monday - the day of CA's birthday. Whether a professional would have been able to make contact with CA in that time in unknown but unlikely. A discussion regarding alcohol use and CA's birthday as a trigger may have been useful, however it is clear from the practitioners that knew CA that they were insightful and aware of the link between alcohol and self-harm.

10.10 The introduction of the Adult Multi-agency Safeguarding Hub (MASH) will improve information sharing. Had a safeguarding referral been made now via the MASH, then information sharing would take place with agencies working with the subject of the referral. So in similar circumstances, if a person was referred following self-harm, agencies such as the CRC would become aware and be able to respond. Again the timeliness of this is a matter to be explored and it is therefore a recommendation is that the case of CA is tested within the Adult MASH.

Support services

10.11 It is evident that CA was offered appropriate services and in the three months prior to their death demonstrated good engagement with these services. Those working with CA described CA as insightful and starting to feel positive about the future.

10.12 CA was referred to the complex cases psychology services and had an appointment due at the end of March 2016. This service was appropriate for CA as it offers a service to patients whose drugs or alcohol misuse prevents active, collaborative engagement in a reflective psychological therapy and patients presenting with as a significant risk to self or others. The referral had been made on 12th August 2015, the average waiting time being 354 days. At the point of their first appointment being offered, CA had been on the waiting list for 162 days. This is an extremely long waiting time, despite being less than half the average. It is imperative that assurance is sought regarding waiting list management and that a cases priority is reassessed and reconsidered in light of new information/rising concerns.

10.13 The IDVA services that were provided focused upon CA's mother as the survivor of domestic abuse. CA was viewed as the perpetrator and as such CA's needs were not considered. It is recognised that there is progress to be made in the development of a greater understanding of and a more robust response to interfamilial violence and abuse, in particular child to parent. Given CA's vulnerabilities and experiences of domestic abuse, consideration of CA's support needs should have been evidenced within the MARAC.

Care Coordination and multi-agency working

10.14 CA was not assessed as requiring care coordination within mental health services as their needs were being met without duplication. There was also the concern that CA might become over dependent upon services although it is not clear from where this concern arose. The decision was made for CA to remain under the care of outpatient psychiatry.

10.15 It is of concern that there was no central point of contact, no identified lead agency, and on occasion an absence of effective and timely information sharing.

10.16 The MARAC held was a significant point of multi-agency communication, and had CA been considered effectively at this stage, a lead agency could have been identified by the MARAC.

10.17 There was evidence of written communication between health agencies and externally to CA's GP. There was also evidence of the MODEL staff viewing information on the mental health trust data base – AMIGOS but not consistently recording their information within the same database. The relevant trusts have now merged and will be adopting a new single recoding system which will improve information exchange considerably.

10.18 It is evident that there was some disconnect between CA's presentation to agencies who were working with CA on a planned basis (and who were reporting a positive picture) and CA's presentations in crisis and out of hours. The SAR panel felt that it was likely that emergency personnel (such as the police and A & E staff) feel a sense of reassurance from

community ‘daytime’ services involvement and that this may serve to lower the perception of risk.

11. Conclusion

11.1 It is evident that CA was a troubled young person, who had developed over the years poor coping mechanisms which included self-harm, alcohol and substance misuse. Relationships were difficult for CA and their personal support network appeared to be weak. CA did however demonstrate an ability to engage with professionals and showed insight into their difficulties but this level of self-awareness and therefore self-protection was compromised when under the influence, predominantly, of alcohol.

11.2 In times of crisis, CA was known to be violent, aggressive, and to express suicidal ideation. Professionals who came into contact with CA during points of crisis responded effectively, although systems for notification of crises to front line staff is an area where communication could have been improved, if the systems are set up to allow for this to happen in an timely and efficient manner.

11.3 CA was in receipt of appropriate services although the waiting list for psychological therapy was significant and is of concern. Successful long term engagement with psychological therapy may have helped CA to manage the root of their difficulties and build effective, healthy coping strategies.

11.4 Improved communication could have occurred, and greater coordination of the agencies working with CA, including the identification of a lead agency. A safeguarding referral could have been made by the three agencies who had contact with CA on 11th March 2016 where CA initially expressed threats to kill themself on their birthday. A referral was not made by any agency. Whether this would have resulted in contact being made with CA, given the time factors as identified within this report, and whether it would have altered the tragic outcome for CA is unknown.

12. Recommendations

12.1 MSAB issue a multi-agency referral pathway and associated guidance that stipulates the responsible agency for making referrals. Agencies should not rely on others to pass on their concerns.

12.2 Adult CA's case is tested via the Adult MASH to determine how CA would have been responded to today.

12.3 Assurance is sought regarding waiting list management of psychological therapy referrals.

12.4 Domestic abuse services should consider a 'think family' approach and where there are concerns that the perpetrator has experienced domestic abuse, these should feature in MARAC discussions and support/safety planning put in place. The MARAC should identify the lead agency following such discussions.

12.5 Agencies should give consideration of mobile phone policies to cover expectations for usage by service users and out of office hours.